HCA – Questions

1. What are the hospital's goals for participation in payment reform initiatives in 2018 and in the next five years?

   a. What steps will the hospital take to meet these goals?
   b. Please describe the reasons why the hospital has chosen not to participate in the risk-based Accountable Care Organization payment models offered to date. If the decision was informed by financial modelling, please provide the model specification, model inputs and results.
   c. Does the hospital participate in any capitated payment agreements directly with insurers? If yes, please describe:

      i. Whether the capitated payments save the insurer money compared to fee for service payments;
      ii. Whether the hospital and/or its providers earn more profit under capitated payments or fee for service, on average; and
      ii. How the hospital ensures that patients continue to receive appropriate services under capitated payments.

   RRMC will not be able to participate in a full two-sided risk contract in 2018. Most importantly, our region's primary care provider (Community Health Centers of the Rutland Region) is not willing to participate at this stage. RRMC would have considered being at full risk in '18 if they had agreed. We will participate in the Shared Savings model in 2018 through CHAC.

   RRMC still believes the APM model with two-sided risk is the right approach. We are hopeful that the experience in '18 will convince our partners and RRMC that it is viable and that the details are appropriate. To be ready for this, RRMC will continue to do work in four areas:

   - We will build a community-wide care management system that combines the case management functions of RRMC, CHCRR and other community providers.
   - We will continue to build data feeds and a data warehouse that will allow us to analyze the information required to be successful.
   - We will review the offerings, risk and financial model proposed to ensure we can accept it.
   - We will alter our physician compensation program to ensure aligned incentives.

2. Please describe the financial incentives that the hospital currently includes in provider, coder, and other salaries and/or contracts.

    a. How has the use of incentives by the hospital changed over time?

    RRMC has a formal physician compensation program that is based on Work Relative Value Unit (WRVU) production. Work Relative value units (RVUs) are a measure of value used in the Medicare reimbursement formula for physician services and are a method for calculating the volume of work or effort expended by a physician in treating patients. Not all physicians have a productivity based compensation incentive. Physician departments where physicians work fixed shifts such as hospitalists, emergency medicine, psychiatrists, and intensivist are paid a fixed salary or their compensation is based on the number of shifts worked. In general, physicians who do not work shifts, have the potential to earn productivity based incentive compensation based on Work RVUs. Physician specialties that have a productivity based incentive include orthopedic surgeons, general surgeons, urologists, gastroenterologists, endocrinologists, otolaryngologists, physiatrists, pulmonologists and cardiologists. For these specialists their total compensation includes a base salary that is valued on a minimum number of WRVUs, and they have the potential to earn productivity based compensation for WRVUS that exceed their base. We are progressively including quality performance metrics into physician compensation agreements. We initially included a quality incentive in orthopedic surgeon and emergency medicine compensation and are expanding quality incentives to hospital medicine. Our work plan for 2018 includes efforts to significantly expand these areas to ensure that provider incentives are consistent with the goals of the All Payer Model.

    In cases of hard to fill positions and in positions that require temporary contract staffing we will consider offering a sign-on or retention bonus or provide tuition repayment. These incentive payments are structured in a way that requires staff to commit to employment at RRMC for a specified length of time. Should the employee not meet the commitment period included in the agreement than all or a portion of the bonus is payable back to the RRMC.

3. Does the hospital or any of its departments or personnel receive financial or other benefits for using specific pharmaceuticals?

    RRMC is not incentivized by any pharmaceutical manufacturer to use their drug. As a result, RRMC receives no payment for the prescribing or administration of drugs outside of funds received by insurance payers for providing medication to patients.

    However, RRMC does receive rebates from drug manufacturers:
    1. As part of improved pricing contracts negotiated by our Group Purchasing Organization (Vizient) on our behalf.
    2. As part of our self-insured prescription benefit, which is limited only to covered lives who partake in our employee insurance offerings.

    a. Please list all pharmaceuticals for which the hospital or provider receives payment when the drug is prescribed, administered, and/or when the prescription is filled.

RRMC receives payment from community retail pharmacies for filled prescriptions that are eligible as part of the federal 340B Contract Pharmacy program.

4. With the various payment reform initiatives underway, shared decision-making is becoming increasingly important as an antidote to the potentially perverse incentives of risk-based payment models.

   a. Do you commit to implementing shared decision-making throughout your hospital system in 2018?

   b. Please describe your plan for doing so and how you will measure the plan's implementation progress.

RRMC believes in shared decision-making and is committed to using it whenever practical. We strongly believe that patients are the key decision makers around their own care. At RRMC this comes about because of sharing information with them so that the decisions can be informed. This happens through our medical homes. It happens in specialty offices. We are strengthening our care management functions to ensure that the patient's wishes are always at the center of every decision. A particularly difficult element of this is at end of life. To this end, we have a robust program to ensure patient's wishes are known in advance. We have two palliative care nurses who are particularly expert in helping patients and families with these critical decisions.

5. What is the extent of your Choosing Wisely initiative(s), if any? Please describe the initiative(s), how you have chosen which departments participate, and which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement.

We have used Choosing Wisely in a variety of areas at RRMC. One of the most formal analyses has been done in radiation oncology. Dr. Rick Lovett has presented this research formally at RSNA and other national forums. His slide deck is attached.

The second formal project was to optimize the use of lab tests by hospitalists. That review is also attached.

6. Please provide copies of your financial assistance policy, application, and plain language summary as well as detailed information about the ways in which these three items can be obtained by patients.

Our financial assistance policy, application and plan language summary are attached. We provide numerous communication mechanisms to our patients to ensure they are aware of our financial assistance program. The three links below will launch each of the three documents. We have six formal communication mechanisms as outlined below.

Policy > http://www.rrmc.org/app/files/public/1430/FAP-Policy_2017.pdf
Application > http://www.rrmc.org/app/files/public/533/pdf-forms-FreeCareForm.pdf
PL Summary > http://www.rrmc.org/app/files/public/1345/FAP-Summary.pdf

Rutland Regional will:

1. Post information on Rutland Regional's website, http://www.rrmc.org/patient-visitors/billing-insurance/financial-assistance/ regarding Government Assistance Programs and the Rutland Regional FAP, including copies of the FAP, FAP plain

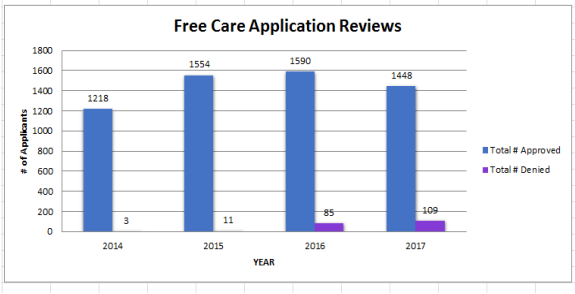
language summary, guidelines for qualification, contact information and application forms;

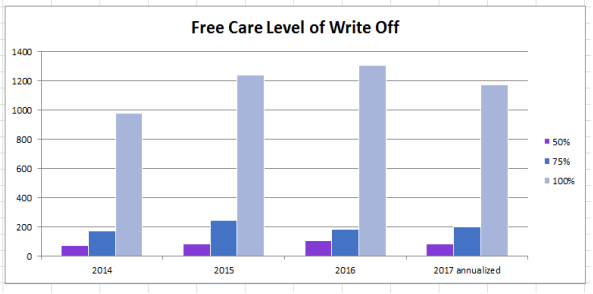
2. Notify patients of the FAP at the time of registration, check-in or prior to discharge. A FAP plain language summary will be provided.
3. Post "Need Help Paying Your Bill" signs in all public areas which include Financial Counselors contact information;
4. Include FAP plain language summary, guidelines for qualification, and contact information on the back of all patient billing statements.
5. Mention FAP to the individual when discussing the bill over the phone or in e-mail. FAP plain language summary brochure and application will be mailed when:
    a. Financial Counselor is calling the patient to ask them to develop a payment plan,
    b. The patient calls to request it.
6. Provide information in the Financial Assistance Program Policy located on Rutland Regional's website: http://www.rrmc.org/app/files/public/1430/FAP-Policy_2017.pdf

a. Please provide the following data by year, 2014 to 2017 (to date):

i. Number of people who were screened for financial assistance eligibility;
ii. Number of people who applied for financial assistance;
iii. Number of people who were granted financial assistance by level of financial assistance received
iv. Number of people who were denied by reason for denial.
v.

RRMC provides a comprehensive Financial Assistance program to meet the healthcare needs of the RRMC community. Free Care expense is expected to continue at the current levels into 2018 driven by patient need. For the first 10 months of the year (October through July) there have been 1,298 applications reviewed, of these applications 93% were determined to meet program eligibility requirements. The two graphs below summarize a four-year trend of Financial Assistance application activity.





RRMC's free care program is based on the 2017 Federal Poverty guidelines. There is a sliding care with varying levels of free care coverage. Patients whose earnings are less than 300% of the federal poverty levels receive full free care. Patients with income between 301% and 500% of the federal poverty level receive partial free care and share in the cost of their care. Our guidelines for approving free care are outlined in the following grid:

2017 Federal Poverty Guidelines

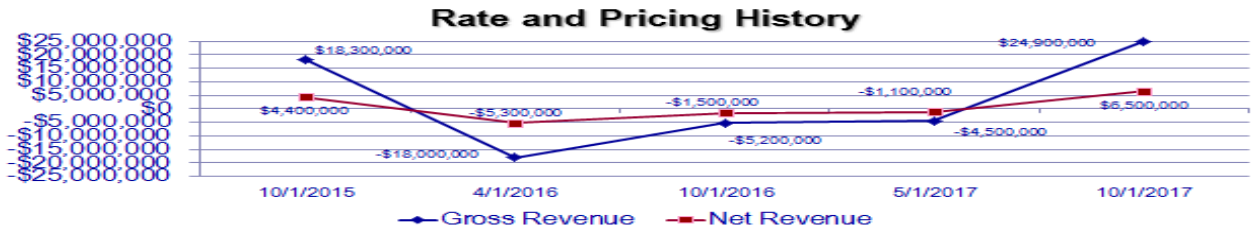
Persons in Family or Household	90% FPL for SSI	100% FPL	Medicaid 133% FPL	ADAP 250% FPL	Up to 300% FPL	301-400% FPL	401-500% FPL
1	$10,692	$11,880	$15,800	$29,700	$35,640	$47,520	$59,400
2	$14,418	$16,020	$21,307	$40,050	$48,060	$64,080	$80,100
3		$20,160	$26,813	$50,400	$60,480	$80,640	$100,800
4		$24,300	$32,319	$60,750	$72,900	$97,200	$121,500
5		$28,440	$37,825	$71,100	$85,320	$113,760	$142,200
6		$32,580	$43,331	$81,450	$97,740	$130,320	$162,900
7		$36,730	$48,851	$91,825	$110,190	$146,920	$183,650
8		$40,890	$54,384	$102,225	$122,670	$163,560	$204,450
Allowed Discount		100%	100%	100%	100%	75%	50%
Amount Owed		0%	0%	0%	0%	25%	50%

Grimm Fund Rutland City **Agan Fund** Ludlow Residents **Goodrich Fund** Maternity Only

Medicare applicants will be denied when liquid assets are more than the Medicare Low Income Beneficiary Limitation:
Single $7,280
Couple $10,930

7. As a nonprofit with a duty to benefit the community, how does the hospital ensure that its commercial rates are in the best interest of consumers? Please provide specific metric(s) that the hospital uses to determine this. For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

RRMC utilizes State of Vermont provided Act 53 data, a subscription service of Medicare claims and internal analysis and calculations that depict the cost to provide the service to determine RRMC patient price. RRMC has implemented three rate decreases in the last 18 months which directly benefit the commercial patient population. In total we have lowered are rates by $27.7 million or 6.2%. See graph below. RRMC has complied with the Green Mountain Care Board 3.4% net patient revenue increase. RRMC has lowered operating margin expectations to 2.5%, opposed to 3% to 3.5% in previous years. An operating margin is still required to allow RRMC to fund cash requirements for debt repayment, pension funding and capital needs. In addition, RRMC continues to reduce costs through operating efficiencies and focused initiatives.



8. We often hear from hospitals that they charge extra for a wide variety of services in order to fund core hospital services. In light of this business model, how does the hospital ensure that the prices of its services are set appropriately?

   a. What factors are considered in setting prices?

b. What financial or quantitative metrics does the hospital use to ensure that its service pricing is appropriate? For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

See response to question #7 above

9. For the hospital's inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2017 budget and projected) and 2018 (budget).

RRMC				
ALL PAYER CASE MIX INDEX				
FISCAL YEAR	EXTENDED WEIGHT	CMI	TOTAL DISCHARGES	COST PER ADJ DISCHARGE
10/1/2013-9/30/2014	7907.1039	1.2613	6352	$ 13,844.27
10/1/2014-9/30/2015	8326.509	1.3244	6297	$ 14,672.14
10/1/2015-9/30/2016	9250.4196	1.3588	6785	$ 14,673.53
10/1/2013-7/31/2017 ytd	7762.8076	1.3648	5662	$ 15,340.80
FY17 Budget		1.4900	6592	$ 15,470.00
Projected FY17 **		1.4900	6524	$ 16,045.00
FY18 Budget		1.3648	6529	$ 16,554.00
** as of March 2017				